FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040071

Facility Name: MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER

Address: 1400 WEST MONROE (Number) CHICAGO (City) 60607 (Zip Code)

County: COOK

Telephone Number: (312)666-4090 **Fax #** (312)421-0134

IDPA ID Number: 36-3961690001

Date of Initial License for Current Owners: 7/1/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) _____

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	136	Intermediate (ICF)	136	49,776	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,776	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	45,754	818	1,484	48,056	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,754	818	1,484	48,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.54%

D. How many bed-hold days during this year were paid by Public Aid? 457 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None provided.

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILIC # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	157,898	15,786	4,890	178,574		178,574		178,574			1
2	Food Purchase		184,216		184,216	(9,743)	174,473	(412)	174,061			2
3	Housekeeping	170,594	37,537		208,131		208,131		208,131			3
4	Laundry		6,756		6,756		6,756	(1,303)	5,453			4
5	Heat and Other Utilities			97,716	97,716		97,716	482	98,198			5
6	Maintenance	55,256	28,693	42,013	125,962		125,962	835	126,797			6
7	Other (specify):*							(12)	(12)			7
8	**TOTAL General Services**	383,748	272,988	144,619	801,355	(9,743)	791,612	(410)	791,202			8
	B. Health Care and Programs											
9	Medical Director			7,000	7,000		7,000		7,000			9
10	Nursing and Medical Records	1,108,149	38,004	6,722	1,152,875		1,152,875	(30,483)	1,122,392			10
10a	Therapy											10a
11	Activities	101,701	2,183	2,023	105,907		105,907		105,907			11
12	Social Services			3,140	3,140		3,140		3,140			12
13	Nurse Aide Training	5,551		1,309	6,860		6,860		6,860			13
14	Program Transportation			154	154		154	1,129	1,283			14
15	Other (specify):*							115	115			15
16	**TOTAL Health Care and Programs**	1,215,401	40,187	20,348	1,275,936		1,275,936	(29,239)	1,246,697			16
	C. General Administration											
17	Administrative	80,548		262,967	343,515		343,515	(189,997)	153,518			17
18	Directors Fees											18
19	Professional Services			58,625	58,625		58,625	(15,737)	42,888			19
20	Dues, Fees, Subscriptions & Promotions			31,267	31,267		31,267	(16,751)	14,516			20
21	Clerical & General Office Expenses	47,720	22,598	44,307	114,625		114,625	59,788	174,413			21
22	Employee Benefits & Payroll Taxes			257,178	257,178	9,743	266,921		266,921			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,627	3,627		3,627	(131)	3,496			24
25	Other Admin. Staff Transportation			535	535		535	92	627			25
26	Insurance-Prop.Liab.Malpractice			39,550	39,550		39,550	154	39,704			26
27	Other (specify):*							15,554	15,554			27
28	**TOTAL General Administration**	128,268	22,598	698,056	848,922	9,743	858,665	(147,028)	711,637			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,727,417	335,773	863,023	2,926,213		2,926,213	(176,677)	2,749,536			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER
0040071
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	9,743	
2	FOOD		9,743

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH C #0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,096	45,096		45,096	74,845	119,941			30
31	Amortization of Pre-Op. & Org.			5,364	5,364		5,364		5,364			31
32	Interest			35,084	35,084		35,084	466,394	501,478			32
33	Real Estate Taxes			73,230	73,230		73,230		73,230			33
34	Rent-Facility & Grounds			753,292	753,292		753,292	(747,280)	6,012			34
35	Rent-Equipment & Vehicles			4,858	4,858		4,858	3,918	8,776			35
36	Other (specify):*											36
37	**TOTAL Ownership**			916,924	916,924		916,924	(202,123)	714,801			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							20	20			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,664	74,664		74,664		74,664			42
43	Other (specify):*	16,090			16,090		16,090	(16,090)				43
44	**TOTAL Special Cost Centers**	16,090		74,664	90,754		90,754	(16,070)	74,684			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,743,507	335,773	1,854,611	3,933,891		3,933,891	(394,870)	3,539,021			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	71,670	30		9
10	Interest and Other Investment Income	(1,324)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(219)	25		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,500)	21		24
25	Fund Raising, Advertising and Promotional	(3,953)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(397)	20		28
29	Other-Attach Schedule	(70,023)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,777)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(368,093)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (368,093)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (394,870)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER

ID# 0040071

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	C.O.P.E.	(219)	20	2
3	Marketing Salary	(16,090)	43	3
4	Political Contribution	(1,500)	20	4
5	Charitable Contribution	(12,800)	20	5
6	Veteran's Medical Exp	(4,791)	10	6
7	Veteran's Pharmacy Exp	(20,459)	10	7
8	Resident Clothing	(1,303)	4	8
9	Patient Needs	(5,854)	10	9
10	1998 Seminar Expense	(762)	24	10
11	Penalty - Parking ticket	(50)	21	11
12	Legal - 1999 service	(176)	19	12
13	Replacement Tax	(5,315)	21	13
14	Misc. Income - Telephone	(193)	21	14
15	Misc. Income - Food	(381)	2	15
16	Misc. Income - Copying	(104)	21	16
17	Misc. Income - Gas	(26)	5	17
18				18
19				19
20				20
21				21
22				22
23				23
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87				87
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89				89
90	**Total**	(70,023)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH C # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(412)											(412)	2
3	Housekeeping													3
4	Laundry	(1,303)											(1,303)	4
5	Heat and Other Utilities	(26)		508									482	5
6	Maintenance			835									835	6
7	Other (specify):*			(12)									(12)	7
8	**TOTAL General Services**	(1,741)		1,331									(410)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(31,104)		621									(30,483)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			1,129									1,129	14
15	Other (specify):*			115									115	15
16	**TOTAL Health Care and Programs**	(31,104)		1,865									(29,239)	16
	C. General Administration													
17	Administrative				(197,682)	7,685							(189,997)	17
18	Directors Fees													18
19	Professional Services	(176)		1,253		(16,814)							(15,737)	19
20	Fees, Subscriptions & Promotions	(18,869)		1,796		322							(16,751)	20
21	Clerical & General Office Expenses	(28,162)		85,659		2,291							59,788	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(762)		618		13							(131)	24
25	Other Admin. Staff Transportation	(219)		311									92	25
26	Insurance-Prop.Liab.Malpractice			154									154	26
27	Other (specify):*			12,526	1,692	1,336							15,554	27
28	**TOTAL General Administration**	(48,188)		102,317	(195,990)	(5,167)							(147,028)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,033)		105,513	(195,990)	(5,167)							(176,677)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH C # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	71,670		3,175									74,845	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,324)	469,205	(1,487)									466,394	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(753,292)	6,012									(747,280)	34
35	Rent-Equipment & Vehicles			3,918									3,918	35
36	Other (specify):*													36
37	**TOTAL Ownership**	70,346	(284,087)	11,618									(202,123)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			20									20	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(16,090)											(16,090)	43
44	**TOTAL Special Cost Centers**	(16,090)		20									(16,070)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,777)	(284,087)	117,151	(195,990)	(5,167)							(394,870)	45

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Monroe Associates	Chicago	Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 753,292	MONROE ASSOCIATES	100.00%	$	$ (753,292)	1
2	V	32	Interest Expense		MONROE ASSOCIATES	100.00%	469,205	469,205	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 753,292			$ 469,205	$ * (284,087)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 508	$ 508	15
16	V	6	REPAIRS AND MAINT.				835	835	16
17	V	7	EMPLOYEE BEN. GEN. SERV.				(12)	(12)	17
18	V	10	NURSING ADMIN. COMP.				621	621	18
19	V	14	PROGRAM TRANSPORTATION				1,129	1,129	19
20	V	15	HEALTHCARE BENEFITS				115	115	20
21	V	19	PROFESSIONAL FEES				1,253	1,253	21
22	V	20	FEES SUBSCRIPTIONS				1,796	1,796	22
23	V	21	CLERICAL & GENERAL				85,659	85,659	23
24	V	24	SEMINARS AND EDUCATION				618	618	24
25	V	25	ADMIN. STAFF TRAVEL				311	311	25
26	V	26	INSURANCE				154	154	26
27	V	27	EMPLOYEE BEN. GEN. ADMIN.				12,526	12,526	27
28	V	30	DEPRECIATION				3,175	3,175	28
29	V	32	INTEREST EXPENSE				(1,487)	(1,487)	29
30	V	34	BUILDING RENT				6,012	6,012	30
31	V	35	EQUIPMENT RENTAL				3,918	3,918	31
32	V	39	ANCILLARY				20	20	32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 117,151	$ * 117,151	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN - R. HARTMAN		NUCARE SERVICES CORP	100.00%	53,285	$ 53,285	15
16	V	17	ADMIN - B. CARR		NUCARE SERVICES CORP	100.00%	11,583	11,583	16
17	V	17	ADMIN - D. HARTMAN		NUCARE SERVICES CORP	100.00%	417	417	17
18	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP	100.00%	1,129	1,129	18
19	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP	100.00%	528	528	19
20	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP	100.00%	35	35	20
21	V								21
22	V	17	MANAGEMENT FEES	262,967	NUCARE SERVICES CORP	100.00%		(262,967)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 262,967			$ 66,977	$ * (195,990)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 7,685	$ 7,685	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		186	186	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		322	322	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		2,291	2,291	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK		13	13	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		1,336	1,336	20
21	V								21
22	V								22
23	V								23
24	V	19	MANAGEMENT FEES	17,000	CAREPATH HEALTH NETWORK		0	(17,000)	24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,000			$ 11,833	$ * (5,167)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE BENEFITS	$ 21,525	DIAMOND INSURANCE	40.00%	$ 21,525	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,525			$ 21,525	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVIL # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HARTMAN	OWNER	ADMINISTRATIV	60.75	SEE ATTACHED	2.7	4.15	Alloc. Salary	$ 53,285	17-7	1
2	BARRY CARR	OWNER	ADMINISTRATIV	4.75	SEE ATTACHED	3	5.45	Alloc. Salary	11,584	17-7	2
3	DAVID HARTMAN	RELATIVE	ADMINISTRATIV	0.00	SEE ATTACHED	0.4	0.89	Alloc. Salary	417	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 65,286		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	634,333	8	$ 6,475	$	49,776	$ 508	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	634,333	8	10,636	(714)	49,776	835	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	634,333	8	(156)		49,776	(12)	3
4	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	634,333	8	7,912	6,671	49,776	621	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	634,333	8	14,386		49,776	1,129	5
6	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	634,333	8	1,462		49,776	115	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	634,333	8	15,970		49,776	1,253	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	634,333	8	22,883		49,776	1,796	8
9	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	634,333	8	1,091,620	894,249	49,776	85,659	9
10	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	634,333	8	7,875		49,776	618	10
11	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	634,333	8	3,960		49,776	311	11
12	26	INSURANCE	AVAIL. CENSUS DAYS	634,333	8	1,958		49,776	154	12
13	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	634,333	8	159,629		49,776	12,526	13
14	30	DEPRECIATION	AVAIL. CENSUS DAYS	634,333	8	40,461		49,776	3,175	14
15	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	634,333	8	(18,956)		49,776	(1,487)	15
16	34	BUILDING RENT	AVAIL. CENSUS DAYS	634,333	8	76,619		49,776	6,012	16
17	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	634,333	8	49,932		49,776	3,918	17
18	39	ANCILLARY	AVAIL. CENSUS DAYS	634,333	8	253	208	49,776	20	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,492,919	$ 900,414		$ 117,151	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	8	720,633	720,000	3	53,285	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40	8	154,447	151,667	3	11,583	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	12	8	12,200	12,000	0	417	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	3,500	3,500			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	8	15,274		3	1,129	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40	8	7,034		3	528	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	12	8	1,028		0	35	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	317				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,433	$ 887,167		$ 66,977	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	17,000	$ 7,685	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		17,000	186	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		17,000	322	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	17,000	2,291	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		17,000	13	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		17,000	1,336	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 11,833	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DIAMOND INSURANCE
Street Address: 40 SKOKIE BLVD - SUITE 105
City / State / Zip Code: NORTHBROOK, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	DIAMOND INSURANCE	DIRECT ALLOCATION			$	$		$ 21,525	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 21,525	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILI(# 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loan	X		Working Capital	Interest Only			As needed			35,084	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 35,084	9
	B. Non-Facility Related*											
10	Supplemental Schedule							660,000			466,394	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 660,000			$ 466,394	14
15	TOTALS (line 9+line14)						$	$ 660,000			$ 501,478	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (1,324)	1
2	Shareholder Loan	X						400,000				2
3	Due to Affiliates - Distributions	X						260,000				3
4	Alloc. From NuCare	X									(1,487)	4
5	Monroe Associates	X									469,205	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 660,000			$ 466,394	21

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	40,838	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	73,504	2
3. Under or (over) accrual (line 2 minus line 1).	$	32,666	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,564	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	73,230	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	69,916	8
	1996	72,004	9
	1997	72,956	10
	1998	74,251	11
	1999	73,504	12

1999 Real Estate Tax Accrual:
$73,753 * 1.05% = $77,441 less 3/01installment payment of $36,877
Line 2 Taxes Paid: 1999 2nd Installment $36,627; 2000 1st Installment $36,877
Total: $73,504

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,004 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 80,453
2. Number of Years Over Which it is Being Amortized: 15 years
3. Current Period Amortization: 5,364
4. Dates Incurred: 1994

Nature of Costs: Goodwill: accrued sick and vacation pays
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	39,159	1982	$ 30,464	1
2					2
3	TOTALS	39,159		$ 30,464	3

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	136		1982	1978	$ 2,059,134	$	26	$ 79,197	$ 79,197	$ 1,508,624	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	13,951	358	20	358		2,252	9
10	Various			1995	13,124	335	20	657	322	3,717	10
11	REPAIR ALARM & PHONE			1996	3,282	96	20	164	68	803	11
12	JOCKEY PUMP			1996	1,200	31	20	60	29	260	12
13	NETWORK-CABLING			1996	1,739	45	20	87	42	355	13
14	ELEVATOR-MOTOR			1996	3,263	84	20	163	79	693	14
15	PATIO-MASONRY			1996	3,650	94	20	183	89	793	15
16	REMODEL LOUNGE			1996	3,174	81	20	159	78	795	16
17	ELEVATOR-LEVELING			1996	1,770	45	20	89	44	363	17
18	WINDOWS			1996	1,116	29	20	56	27	275	18
19	SPRINKLER REPAIR			1997	1,126	29	20	56	27	182	19
20	FIRE DOORS			1997	1,381	35	20	69	34	213	20
21	COMM.SYSTEM			1997	1,024	36	20	51	15	209	21
22	SPRINKLER UPGRADE			1997	5,235	134	20	262	128	830	22
23	WALLPAPER & PAINT			1997	12,984	333	20	649	316	2,596	23
24	PAGE 12-2 REP TOTALS				86,704			4,380	4,380	52,063	24
25	PAGE 12-1 REP TOTALS				1,661	122		68	(54)	141	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				58,806	1,101		2,090	989	2,090	32
33	PAGE 12C TOTALS				26,691	665		1,263	598	1,896	33
34	PAGE 12B TOTALS				51,294	1,314		2,561	1,247	4,723	34
35	PAGE 12A TOTALS				52,297	1,341		2,616	1,275	6,685	35
36	TOTAL (lines 4 thru 35)				$ 2,404,606	$ 6,308		$ 95,238	$ 88,930	$ 1,590,558	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FIRE ALARM SYSTEM			1997	2,334	60	20	117	57	380	9
10	ELEVATOR REPAIRS			1997	2,092	54	20	105	51	324	10
11	RPZ VALVES			1997	1,073	28	20	54	26	203	11
12	FRONT DOOR REPAIR			1997	938	24	20	47	23	153	12
13	FIRE PROOF BEAM			1997	642	16	20	32	16	104	13
14	SPRINKLER UPGRADE			1997	1,620	42	20	81	39	250	14
15	COMPRESSOR VALVES			1997	1,026	26	20	51	25	179	15
16	SIGNAGE			1997	890	23	20	45	22	150	16
17	PARTITION FOR WASHRO			1998	5,818	149	20	291	142	655	17
18	CEILING RADIATION DA			1998	3,050	78	20	153	75	344	18
19	FIRE DAMPERS REPAIR			1998	663	17	20	33	16	96	19
20	FIRE DAMPERS INSTALL			1998	1,927	49	20	96	47	200	20
21	FIRE & SMOKE DAMPER			1998	1,481	38	20	74	36	204	21
22	LIFE SAFETY REPAIR			1998	453	12	20	23	11	63	22
23	CABE INSTALLATION			1998	3,484	89	20	174	85	479	23
24	WALLPAPERING ADMIN O			1998	1,500	38	20	75	37	188	24
25	RESULT HEAT EXCHANGE			1998	1,498	38	20	75	37	169	25
26	TWO FIRE DOORS			1998	690	18	20	35	17	76	26
27	SPRINKLER REPAIR			1998	1,620	42	20	81	39	216	27
28	LIFE SAFETY CODE REP			1998	1,143	29	20	57	28	162	28
29	FIRE ALARM REPAIR			1998	656	17	20	33	16	96	29
30	CAST IRON SECTIONAL			1998	8,648	222	20	432	210	1,008	30
31	AUDIO SYSTEM REPAIR			1998	818	21	20	41	20	120	31
32	SPRINKLE SYSTEM ELEC			1998	3,962	102	20	198	96	281	32
33	RADIATOR REPAIR			1998	2,762	71	20	138	67	414	33
34	CEILING TILE			1998	682	17	20	34	17	79	34
35	SPRINKLER SYSTEM REP			1998	827	21	20	41	20	92	35
36	TOTAL (lines 4 thru 35)				$ 52,297	$ 1,341		$ 2,616	$ 1,275	$ 6,685	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1998	1,275	33	20	64	31	165	9
10	TEST STATION			1998	519	13	20	26	13	78	10
11	CEILING TILE			1998	682	17	20	34	17	79	11
12	CEILING TILE			1998	705	18	20	35	17	76	12
13	CEILING TILE			1998	682	17	20	34	17	71	13
14	ELEVATOR MODERATION			1998	1,730	44	20	87	43	181	14
15	CARPETING			1998	2,922	75	20	146	71	365	15
16	CEILING TILE			1998	682	17	20	34	17	74	16
17	WALLPAPER			1999	2,412	62	20	121	59	182	17
18	FLOOR TILE			1999	713	18	20	36	18	72	18
19	LIFE SAFETY REPAIR			1999	685	18	20	34	16	68	19
20	REPAIR FAST&WEST ELE			1999	6,550	168	20	328	160	601	20
21	WORK ON FIRE DAMPERS			1999	4,104	105	20	205	100	410	21
22	LIFE SAFETY REPAIRS			1999	1,664	43	20	83	40	159	22
23	WALLPAPER			1999	8,450	217	20	423	206	776	23
24	REPAIR WATER PUMP&FA			1999	1,178	30	20	59	29	113	24
25	FIRE DOOR PREP			1999	584	15	20	29	14	56	25
26	DIESEL FUEL TANK			1999	2,344	60	20	117	57	205	26
27	TASSOGLASS WALLCOVER			1999	1,981	51	20	99	48	157	27
28	WINDOW TREATMENTS			1999	5,101	131	20	255	124	340	28
29	FURNISH AND INSTALL			1999	1,116	29	20	56	27	112	29
30	DOOR ALARM SYSTEM			1999	1,100	28	20	55	27	110	30
31	BASE COVE			1999	320	8	20	11	3	18	31
32	FURNISH AND INSTALL			1999	426	11	20	21	10	42	32
33	TELEPHONE LINES			1999	436	11	20	22	11	37	33
34	CRASH RAIL & CAPS			1999	630	16	20	32	16	51	34
35	ELEVATOR RELAYS			1999	2,303	59	20	115	56	125	35
36	TOTAL (lines 4 thru 35)				$ 51,294	$ 1,314		$ 2,561	$ 1,247	$ 4,723	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER BORDER			1999	168	4	20	8	4	13	9
10	WALLPAPER BORDER			1999	167	4	20	8	4	13	10
11	COVE BASES			1999	310	8	20	16	8	25	11
12	FURNISH AND INSTALL			1999	487	12	20	24	12	48	12
13	RADIATOR REPAIR			1999	713	18	20	36	18	51	13
14	ELEVATOR COIL REPAIR			1999	981	25	20	49	24	98	14
15	FLOOR TILE			1999	687	18	20	34	16	48	15
16	FRONT DOOR RELEASE			1999	899	23	20	45	22	75	16
17	BASE COVE			1999	6,330	189	20	316	127	469	17
18	WALL MOUNT PULL STAT			1999	555	14	20	28	14	47	18
19	NURSES CALL SYSTEM			1999	1,808	46	20	90	44	180	19
20	TAMPER SWITCHES ON P			1999	716	18	20	36	18	60	20
21	ELEVATOR BEARINGS			1999	904	23	20	45	22	83	21
22	PA & TELEPHONE SERV.			1999	399	10	20	20	10	33	22
23	SPRINKLE SYSTEM			1999	602	15	20	30	15	60	23
24	CCTV SYSTEM			1999	813	21	20	41	20	44	24
25	PA SYSTEM AND CCTV			1999	776	20	20	39	19	52	25
26	ELEVATOR RELAYS			1999	785	20	20	39	19	49	26
27	TELEPHONE SYSTEM			1999	616	16	20	31	15	36	27
28	TELEPHONE SYSTEM			1999	581	15	20	29	14	34	28
29	REPAIR OUTLETS&PHONE			1999	990	25	20	50	25	100	29
30	PHONE SYSTEM & CCTV			1999	581	15	20	29	14	39	30
31	WALL MOUNT FIRE HORN			1999	584	15	20	29	14	48	31
32	REPLACE WIRES			2000	555	13	20	28	15	28	32
33	FURNISH NEW PACKING			2000	512	8	20	17	9	17	33
34	REPAIR ELEVATOR			2000	2,770	44	20	93	49	93	34
35	REWIRE CONTACT			2000	1,402	26	20	53	27	53	35
36	TOTAL (lines 4 thru 35)				$ 26,691	$ 665		$ 1,263	$ 598	$ 1,896	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	600 GALLON TANK			2000	26,300	590	20	1,205	615	1,205	9
10	CCTV SYS & NURSE SYS			2000	961	18	20	36	18	36	10
11	INSTL EXTERIOR LIGHT			2000	648	12	20	24	12	24	11
12	SUPPLY PIPING			2000	2,067	128	20	78	(50)	78	12
13	REPAIR CONTACT			2000	572	14	20	29	15	29	13
14	3 RELAY CONTACTS			2000	879	20	20	40	20	40	14
15	REPLACED RECLAIMER			2000	1,453	20	20	43	23	43	15
16	600 GALLON TANK ADD'N			2000	2,200	49	20	101	52	101	16
17	FIRE ALARM PLANS			2000	2,400	3	20	10	7	10	17
18	CONTROLLER WIRES			2000	2,324	53	20	106	53	106	18
19	DOOR TRACK ROLLERS			2000	754	9	20	19	10	19	19
20	COMPRESSOR FOR WALK-			2000	1,270	10	20	21	11	21	20
21	SERVICE CCTV SYSTEM			2000	1,295	23	20	49	26	49	21
22	DIESEL FUEL TANK			2000	1,000	25	20	50	25	50	22
23	REPL LEVEL SWITCH			2000	1,515	18	20	38	20	38	23
24	TEMPORARY TANK & ASP			2000	1,795	21	20	45	24	45	24
25	CCTV MONITOR			2000	1,066	1	20	4	3	4	25
26	NURSE CALL SYSTEM			2000	502	1	20	2	1	2	26
27	PUMPED 600 GAL WATER			2000	1,530	21	20	45	24	45	27
28	CEILING TILE			2000	740	4	20	9	5	9	28
29	200 GALLON TANK			2000	3,045	23	20	51	28	51	29
30	NEW TUBING FOR RETUR			2000	1,875	14	20	31	17	31	30
31	FURN&INST GLASS & LA			2000	1,054	12	20	27	15	27	31
32	INSTALL 2 WINDOWS			2000	670	11	20	23	12	23	32
33	DOOR ALARM & CCTV SY			2000	891	1	20	4	3	4	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,806	$ 1,101		$ 2,090	$ 989	$ 2,090	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from NuCare			1997	361	9		18	9	58	9
10	Allocated from NuCare			1998	317	8		16	8	39	10
11	Allocated from NuCare			1999	444	100		22	(78)	32	11
12	Allocated from NuCare			2000	539	5		12	7	12	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,661	$ 122		$ 68	$ (54)	$ 141	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Various			1986	32,967		Various	1,741	1,741	25,697	10
11	Various			1987	4,735		19	249	249	3,253	11
12	Various			1988	8,738		19	377	377	4,901	12
13	Various			1989	11,001		20	550	550	6,325	13
14	Various			1990	1,919		20	96	96	1,008	14
15	Various			1991	5,128		20	256	256	2,432	15
16	Various			1992	4,600		20	230	230	1,840	16
17	Various			1993	16,600		20	830	830	6,225	17
18	Various			1993	1,016		20	51	51	382	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 86,704	$		$ 4,380	$ 4,380	$ 52,063	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION I # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 265,052	$ 35,330	$ 22,555	$ (12,775)		$ 79,015	37
38	Current Year Purchases	30,219	6,636	2,151	(4,485)		2,151	38
39	Fully Depreciated Assets	395,450					9,570	39
40								40
41	TOTALS	$ 690,721	$ 41,966	$ 24,706	$ (17,260)		$ 90,736	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Wagon	1991 Ford E150	1994	$ 2,200	$	$	$	4	$ 2,200	42
43										43
44										44
45										45
46	TOTALS			$ 2,200	$	$	$		$ 2,200	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,127,991	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 48,274	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 119,944	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 71,670	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,683,494	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER
0040071
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
MONROE CORP	249,767	32,914	21,236	(11,678)	70,545
NUCARE SERVICES CORP	15,285	2,416	1,319	(1,097)	8,470
PRIOR MONROE					
TOTALS	265,052	35,330	22,555	(12,775)	79,015
LINE 29: CURRENT YEAR					
MONROE CORP	26,973	6,000	1,968	(4,032)	1,968
NUCARE SERVICES CORP	3,246	636	183	(453)	183
PRIOR MONROE					
TOTALS	30,219	6,636	2,151	(4,485)	2,151
LINE 30: FULLY DEPRECIATED					
MONROE CORP	9,570				9,570
NUCARE SERVICES CORP					
PRIOR MONROE	385,880				
TOTALS	395,450				9,570
TOTALS (Should Tie to Totals on Page 13)					
MONROE CORP	286,310	38,914	23,204	(15,710)	82,083
NUCARE SERVICES CORP	18,531	3,052	1,502	(1,550)	8,653
PRIOR MONROE	385,880				
TOTALS	690,721	41,966	24,706	(17,260)	90,736

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NuVision, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978		10/16/98	$ 753,292	10		3
4	Additions	Monroe Associates			(753,292)			4
5		Allocation from NuCare			6,012			5
6								6
7	TOTAL				$ 6,012 **			7

10. Effective dates of current rental agreement:
Beginning 10/16/98
Ending 12/31/2008

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 728,472
13.	/2002	$ 728,472
14.	/2003	$ 728,472

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 8,776 Description: NuCare Allocation $3,918; Copy Machine$4023; Fax Machine $835.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM: [ ]
- IN OTHER FACILITY: [ ]
- COMMUNITY COLLEGE: 120
- HOURS PER AIDE: 120

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM: 80
- IN OTHER FACILITY: [ ]
- HOURS PER AIDE: 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,309	$	$ 1,309
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		5,551		5,551
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 6,860	$	$ 6,860
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,860			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**					20			20	13
14	TOTAL			$		$ 20	$		$ 20	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	NuCare Services Allocation	20
2		
3		
4		
5		
6		
7		
8		
9		
10		
		20

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH (# 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 144,150	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	548,606		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,401		6
7	Other Prepaid Expenses	19,736		7
8	Accounts Receivable (owners or related parties)	1,021,855		8
9	Other(specify): See supplemental schedule	166		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,761,914	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	263,971		15
16	Equipment, at Historical Cost	286,311		16
17	Accumulated Depreciation (book methods)	(221,983)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	45,588		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 373,887	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,135,801	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 112,754	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,314		28
29	Short-Term Notes Payable	660,000		29
30	Accrued Salaries Payable	134,079		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,656		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,564		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	13,780		35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 977,147	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 977,147	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,158,654	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,135,801	$ #REF!	48

*(See instructions.)

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALT # 0040071 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Employee Advances	166				
	166				
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Goodwill	80,453				
Accumulated Amortization on Goodwill	(34,865)				
	45,588				

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,145,068	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,145,068	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	273,586	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(260,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 13,586	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,158,654	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	MONROE CORP. d/b/a MONROE P#	0040071	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,145,068
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,145,068
Equity(Deficit) from Page 17 Col 1		1,158,654
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,158,654

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HI # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,205,449	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,205,449	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,324	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,324	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	704	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 704	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,207,477	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	801,355	31
32	Health Care	1,275,936	32
33	General Administration	848,922	33
	B. Capital Expense		
34	Ownership	916,924	34
	C. Ancillary Expense		
35	Special Cost Centers	16,090	35
36	Provider Participation Fee	74,664	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,933,891	40
41	**Income before Income Taxes (line 30 minus line 40)****	273,586	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 273,586	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MONROE CORP. d/b/a MONROE I # 0040071 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Misc. Income - Telephone (Adjust out on Page 5)	193
2	Misc. Income - Food (Adjust out on Page 5)	381
3	Misc. Income - Copying (Adjust out on Page 5)	104
4	Misc. Income - Gas (Adjust out on Page 5)	26
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	704

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH C # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,485	2,583	$ 91,808	$ 35.54	1
2	Assistant Director of Nursing	1,947	2,971	70,763	23.82	2
3	Registered Nurses	2,031	2,217	44,679	20.15	3
4	Licensed Practical Nurses	17,919	19,670	279,631	14.22	4
5	Nurse Aides & Orderlies	41,586	45,525	355,374	7.81	5
6	Nurse Aide Trainees	894	894	5,551	6.21	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,097	1,131	23,987	21.21	9
10	Activity Assistants	10,381	11,174	77,714	6.95	10
11	Social Service Workers					11
12	Dietician	1,921	2,091	36,798	17.60	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,151	16,433	121,100	7.37	15
16	Dishwashers					16
17	Maintenance Workers	3,222	3,280	55,256	16.85	17
18	Housekeepers	21,985	23,648	170,594	7.21	18
19	Laundry					19
20	Administrator	2,070	2,251	80,548	35.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,850	2,963	47,720	16.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	16,708	17,156	202,631	11.81	28
29	Resident Services Coordinator	2,016	2,020	36,831	18.23	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,287	2,463	26,432	10.73	31
32	Other Health Care(specify)					32
33	Other(specify)	337	337	16,090	47.74	33
34	TOTAL (lines 1 - 33)	146,887	158,807	$ 1,743,507 *	$ 10.98	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 4,890	1-3	35
36	Medical Director	MONTHLY	7,000	9-3	36
37	Medical Records Consultant	MONTHLY	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	2,690	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,023	11-3	44
45	Social Service Consultant	62	3,140	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	114	$ 23,775		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing Salary - adjusted out on Page 5	337	337	16,090	$ 47.74
	337	337	$ 16,090	$ 47.74

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION H # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RICH WALWORTH	ADMINISTRATOR	0	$ 80,548
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,548

B. Administrative - Other

Description	Amount
Management Service - NuCare Services	$ 262,967
TOTAL (agree to Schedule V, line 17, col. 3)	$ 262,967
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting	$ 16,200
SAS Architects	Architect	272
CarePath	Network	17,000
Personnel Planners	UC tax consultant	1,198
Horizon healthcare Technologies	Computer	3,550
Power Software Development	Computer	7,184
CDW Computer Centers	Computer	453
Personnel Planners	Computer	295
Health Data Systems Inc	Computer	2,768
Purchasing Plus	Purchasing	1,221
Various-See Attached	Legal	8,484
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 58,625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,111
Unemployment Compensation Insurance	13,086
FICA Taxes	126,779
Employee Health Insurance	34,608
Employee Meals	9,743
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	19,107
Chicago Head Tax	3,520
Payroll Tax Reimbursed	7,279
Union Pension	12,688
TOTAL (agree to Schedule V, line 22, col.8)	$ 266,921

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,416
Health Care Worker Background Check	1,076
(Indicate # of checks performed 154)	
Yellow Page Advertising	397
Advertising and Promotion	3,953
Dues and Subscriptions	5,448
License, Inspection & Permits	1,677
Allocation from NuCare	1,577
Allocation from CarePath	322
Less: Public Relations Expense	( )
Non-allowable advertising	(3,953)
Yellow page advertising	(397)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,516

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,865
Allocation from NuCare	618
Allocation from CarePath	13
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,496

**See instructions.

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	1994	$ 5,434	3	$ 906	$	$	$	$	$	$	$	$
2	Repairs and Maintenance	1995	4,185	3	1,395	698							
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,619		$ 2,301	$ 698	$	$	$	$	$	$	$

Facility Name & ID Number MONROE CORP. d/b/a MONROE PAVILION HEALTH CENTER # 0040071 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Ill. Council LTC - $4,944

(3) Did the nursing home make political contributions or payments to a politica action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 39 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? X YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
MONROE PAVILION HEALTH CENTER #0040071 - 7/1/94

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 74,664
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 9,743 Has any meal income been offset against related costs? NO Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of line 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw